Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SPINECARE LLP
5734 SPOHN DRIVE
CORPUS CHRISTI TX 78414

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-11-4454-01

MFDR Date Received
AUGUST 3, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier paid the claim at the wrong allowed amount. I sent an appeal to the carrier and their response was that to increase their allowed amount and payment, but it was still below MAR. Therefore this claim is being sent to MFDR for determination."

Amount in Dispute: $50.09

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Code 64494…is subject to the multiple procedure rule that reduced the $219.49 by 50% to $109.74. The total amount paid by Texas Mutual was $109.74...Texas Mutual believes its payment amount is correct and no further payment is due."

Response Submitted by: TMIC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 23, 2010	ASC Services for Code 64494-SG-RT	$50.09	$0.00
TOTAL		$50.09	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits

- W1-Workers compensation state fee schedule adjustment.
- 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
- CAC-59-Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia).
- 420-Supllemental payment.
- 615-Payment for this service has been reduced according to the Medicare multiple surgery guidelines.

Issues

1. Did the requestor support position that additional reimbursement is due for ASC services for code 64494-SG-RT-SG? Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

   CPT code 64494 is defined as "Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)."

   28 Texas Administrative Code §134.402(f) reimbursement for non-device intensive procedure for CPT code 64494 is:

   The Medicare ASC reimbursement rate is found in the Addendum AA ASC Covered Surgical Procedures. The ASC fully implemented relative payment weight for CY 2010 = 2.3866.

   This number is multiplied by the 2010 Medicare ASC conversion factor of 41.873 X $2.3866 = $99.93.

   The Medicare fully implemented ASC reimbursement rate is divided by 2 = $49.96 ($99.93/2).

   This number X City Conversion Factor/CMS Wage Index for Corpus Christi, Texas is $49.96 X 0.8693 = $43.43.

   The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted reimbursement $49.96 + $43.43 = $93.39.

   Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $93.39 X 235% = $219.46.

   CPT code 64494 is subject to multiple procedure discounting; therefore, 219.46 X 50% = $109.73.

   The MAR for CPT code 64494 is $109.73. The insurance carrier paid $109.74. As a result, the amount recommended for additional reimbursement is $0.00.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor. The Division concludes that the requestor did not support its position that additional reimbursement is due. As a result, the amount ordered is $0.00

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		05/28/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.